



HEALTH INFORMATION FORM

Participant First Name: _____ Participant Last Name: _____

Are you in good health? Yes No

Are you able to participate fully in physical exercises? Yes No

If not, what are your limitations? _____

Do you have any chronic conditions or recent illnesses? Yes No

If yes, please explain. _____

Are you on any medication? Yes No

If yes who is responsible for administering this medication? _____

If yes will you need to take it during the day? Please explain _____

Do you have any allergies? Yes No

If yes, please explain _____

Do you have any ear/hearing problems? Yes No

Do you wear glasses? all the time reading only distance not at all

Do you wear contact lenses? Yes No

Do you have a fear of heights? Yes No

When was your last tetanus shot? _____

Are you claustrophobic in a small or dark spaces? Yes No

Is there any other relevant health information we need to know? Yes No

If yes, please explain _____

The participant will be working in an environment with smoke and fire and will be participating in a strenuous and demanding series of activities; many of them modeled on what real firefighters go through during training. Do you see any reason or condition that might affect your ability to participate? Yes No

If yes, please explain _____

Please mail or fax form to:

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